UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Beverly Dionne Joseph

(In the space above enter the full name(s) of the plaintiff(s).)

COMPLAINT

-against-

Ms CAMBA/FJC Block Mustard
Clay Brown Security Guard of
Magnolia House,
1424 Herkimer Street
Brooklyn, New York 11233
On Duty at 11:11 Am Eastern
Standard Time On the 3rd Floor
Saturday, August 08, 2015

Jury Trial: ☒ Yes ☐ No
(check one)

(In the space above enter the full name(s) of the defendant(s). If you cannot fit the names of all of the defendants in the space provided, please write "see attached" in the space above and attach an additional sheet of paper with the full list of names. The names listed in the above caption must be identical to those contained in Part I. Addresses should not be included here.)

I. Parties in this complaint:

A. List your name, address and telephone number. If you are presently in custody, include your identification number and the name and address of your current place of confinement. Do the same for any additional plaintiffs named. Attach additional sheets of paper as necessary.

Plaintiff
Name Beverly Dionne Joseph
Street Address 473 N 8th A 158 Street, Apt # 71
County, City New York, New York
State & Zip Code New York 10032
Telephone Number 917-603-8791

B. List all defendants. You should state the full name of the defendant, even if that defendant is a government agency, an organization, a corporation, or an individual. Include the address where each defendant may be served. Make sure that the defendant(s) listed below are identical to those contained in the above caption. Attach additional sheets of paper as necessary.

Defendant No. 1
Name Ms CAMBA/FJC Block Security Guard On Duty 11:11 Am
Street Address Saturday, August 08, 2015 3rd Floor
Magnolia House - CAMBA
1424 Herkimer Street
Brooklyn, New York 11233

County, City _____

State & Zip Code _____

Telephone Number _____

Defendant No. 2

Name _____

Street Address _____

County, City _____

State & Zip Code _____

Telephone Number _____

Defendant No. 3

Name _____

Street Address _____

County, City _____

State & Zip Code _____

Telephone Number _____

Defendant No. 4

Name _____

Street Address _____

County, City _____

State & Zip Code _____

Telephone Number _____

II. Basis for Jurisdiction:

Federal courts are courts of limited jurisdiction. Only two types of cases can be heard in federal court: cases involving a federal question and cases involving diversity of citizenship of the parties. Under 28 U.S.C. § 1331, a case involving the United States Constitution or federal laws or treaties is a federal question case. Under 28 U.S.C. § 1332, a case in which a citizen of one state sues a citizen of another state and the amount in damages is more than $75,000 is a diversity of citizenship case.

A. What is the basis for federal court jurisdiction? *(check all that apply)*

☒ Federal Questions ☐ Diversity of Citizenship

B. If the basis for jurisdiction is Federal Question, what federal Constitutional, statutory or treaty right is at issue? Americans With Disabilities Act Violations

C. If the basis for jurisdiction is Diversity of Citizenship, what is the state of citizenship of each party?

Plaintiff(s) state(s) of citizenship New York

Defendant(s) state(s) of citizenship New York

III. Statement of Claim:

State as briefly as possible the facts of your case. Describe how each of the defendants named in the caption of this complaint is involved in this action, along with the dates and locations of all relevant events.

You may wish to include further details such as the names of other persons involved in the events giving rise to your claims. Do not cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. Attach additional sheets of paper as necessary.

A. Where did the events giving rise to your claim(s) occur? 3rd Floor Under South East Security Surveillance Camera of Magnolia House - 1424 Herkimer St. Bklyn. N.Y. 11233 @11:11AM 8/08/2015

B. What date and approximate time did the events giving rise to your claim(s) occur? ↗

C. Facts: The Exhibit of my Loveday Color Note Content to the Security Surveillance Camera when the Predator Black Female Mustard Clay Brown Cama/FSC Canine verbally Attacked myself, Beverly Diane Streight as she Seeks myself out For Rear Sneak Attacks Verbally At 11:11 Am August 08, 2015 3rd Floor Magnolia House - CAMBA 1424 Herkimer Street Brooklyn, New York 11233 with Daily Schedule encounters of Harassment.

What happened to you?

Who did what?

Was anyone else involved?

Who else saw what happened?

IV. Injuries:

If you sustained injuries related to the events alleged above, describe them and state what medical treatment, if any, you required and received.

I Am Currently Suffering From A Tremendously Herniated Kicked, in Spine at Tillary Public Government Owned Shelter On June 5, 2015 off of which I am Having Physical Pain And, internal and External Injuries at cot site 5019 of Tillary Street Shelter 200 Tillary Street Brooklyn, N.Y. 11201

V. Relief:

State what you want the Court to do for you and the amount of monetary compensation, if any, you are seeking, and the basis for such compensation.

I Beverly Dionne Joseph I am Requesting A Relief of 900 Billion Dollars and Total Deportation For Violating my ADA Laws, Civil Rights, Human Rights and Constitutional Right and Fair House Rights.

I declare under penalty of perjury that the foregoing is true and correct.

Signed this 11 day of August, 2015.

Signature of Plaintiff Beverly Dionne Joseph

Mailing Address 473 West 158 St
Apt #71
New York, New York 10032

Telephone Number 917-603-8791

Fax Number *(if you have one)* _____

Note: All plaintiffs named in the caption of the complaint must date and sign the complaint. Prisoners must also provide their inmate numbers, present place of confinement, and address.

For Prisoners:

I declare under penalty of perjury that on this _____ day of _____, 20__, I am delivering this complaint to prison authorities to be mailed to the *Pro Se* Office of the United States District Court for the Southern District of New York.

Signature of Plaintiff: _____

Inmate Number _____

(3)

Mazzuchi Assigned Locker and Invades my Privacy and Trespasses by RECEIVED PRO SE OFFICE with my Personal Property inside Lockers; 4011, 3011 and 300-5 2015 SEP -1 A 9:29

2. Daily and Habitually Infringes upon my First Amendment Rights of Our United States of America Constitution "FREEDOM of Speech".

4 Daily and Habitually FTC/Custer Female Blake Bailey Enter my Assigned Magnolia-House Assigned with her Foul Un-Sanitary Pork Rind Femme Body Odors Leaving Risidue of Her Individual scent (Body) Within and upon the content of Assigned Lockers.

5 The Daily and Habitually Condiscending Barks / INSTERS of Communicating Vocally at Myself Beverly Drive Joseph with the Sole Attempt of Re-Ille-ments BASED upon Her Premeditated Bias Malice Personal Beliefs.

Predator Canine Approaches upon myself Beverly Drive Joseph BASED upon Premeditated Malice Beliefs.

BADGE # 7116 I.D. 1010.

TUESDAY, February 11, 2014

00:1:00:00:00:10:00:00:00:90

RECORDS ACCESS OFFICE

NEW YORK STATE DEPARTMENT OF HEALTH

CORNING TOWER, ROOM 2364

ALBANY, NEW YORK 12237-0044

TO WHOM IT MAY CONCERN:

I BEVERLY DIANE JOSEPH BORN BEVERLY DIANE JULIANNIA NOCTRISANSIA JEHOVAHEMIESIA ALLUSTIA DONNOIRÉ-TROMBALÉ UNTO UNITED STATES OF AMERICA MILITARY OFFICER ARTHUR MICHAELS JAMES VILLTALINI-DONNOIRÉ-TROMBALÉ AND HIS WIFE LIANNA HIAACHI-CAVANAUGH-VILLTALINI-DONNOIRÉ-TROMBALÉ IN SAINT ALBANS QUEENS, NEW YORK NAVY HOSPITAL ON SEPTEMBER 27, 1967, WHICH TODAY IS VETERANS ADMINISTRATION AFFAIRS HOSPITAL, NEW YORK.

PLEASE FORWARD ALL MY CORRESPONDENCES AND A COPY OF MY AUTHENTIC AND OFFICIAL AMERICAN BIRTH CERTIFICATE TO MY OLDER SISTER'S RESIDENCE AS FOLLOW:

BEVERLY D. JOSEPH

17 WINDSOR ROAD

GREAT NECK, NEW YORK 11021

ENCLOSED IS A COPY OF MY NEW YORK STATE IDENTIFICATION CARD; MY USS INTERPID IDENTIFICATION CARD; MY UNITED STATES OF AMERICA PASSPORT TO FACILITATE THE PROCESS.

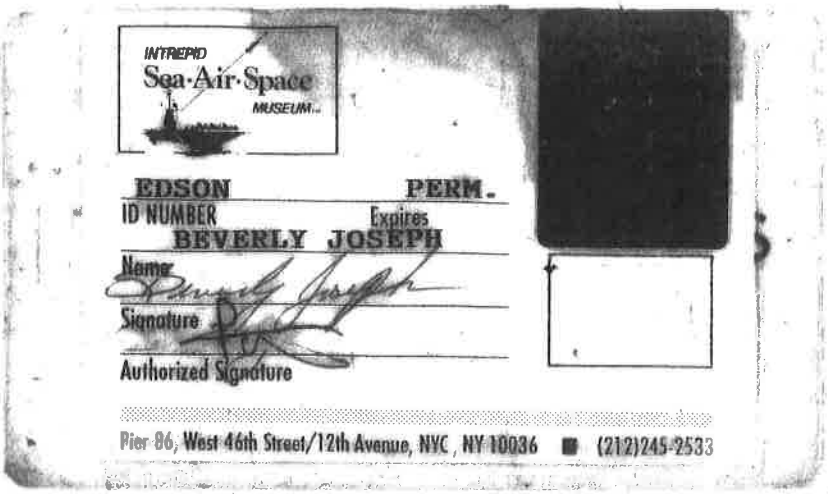
THANK YOU IN ADVANCE FOR YOUR ASSISTANCE WITH THIS MATTER.

BEVERLY DIANE JOSEPH

00:10:00:00:00:19:00:00:00:120:00

2/11/14

SALAH W ALABBASI
Notary Public - State of New York
NO. 01AL6269144
Qualified in New York County
My Commission Expires 9/17/16


INTREPID
Sea·Air·Space
MUSEUM
EDSON
PERM.
ID NUMBER
Expires
BEVERLY JOSEPH
Name
Signature
Authorized Signature
Pier 86, West 46th Street/12th Avenue, NYC, NY 10036 (212)245-2533


We the People
Of the United States,
in Order to form a more perfect Union,
establish Justice, insure domestic Tranquility,
provide for the common defence,
promote the general Welfare, and secure
the Blessings of Liberty to ourselves and
our Posterity, do ordain and establish this
Constitution for the United States of America
SIGNATURE OF BEARER / SIGNATURE DU TITULAIRE / FIRMA DEL TITULAR
PASSPORT
PASSEPORT
PASAPORTE
UNITED STATES OF AMERICA
USA
436951709
JOSEPH
BEVERLY DIANE
UNITED STATES OF AMERICA
27 Sep 1961
United States
Department of State
SEE PAGE 27
USA
P<USAJOSEPH<<BEVERLY<DIANE<<<<<<<<<<<<<<<<<<<<
4369517090USA6109271F1802049227099882<302462

United States District Court
Southern District Of New York
Pro Se Office

Loretta A. Preska
Chief Judge

Ruby J. Krajick
Clerk of Court

INSTRUCTIONS FOR FILING A COMPLAINT

Attached are a complaint form and an application to waive the filing fee for an action in this Court. The instructions for completing them are as follows:

1. **Caption**: The caption is located in the top left corner on the first page of the complaint. You, as the person filing the complaint, are the Plaintiff. The people or entities you allege are responsible for your injuries should be named as the defendants. You should state the full name of the defendant, even if that defendant is a government agency, an organization, or a corporation. You should state the first and last name of individual defendants. If you do not know the name of a defendant, you should name him or her as "John Doe" or "Jane Doe" and include some descriptive information about that defendant. For example, "John Doe Doctor who worked at 4pm at Manhattan Hospital on January 1, 2006."

2. **Jury Trial**: You may be entitled to a trial by jury, but you may lose your right to a jury trial if you do not ask for it early enough. You should indicate on the first page of the complaint whether you want a jury trial by checking either "yes" or "no" in the top right corner of the first page of the complaint. You can also demand a jury trial within 14 days of service of the answer. If you do not request a jury trial, but later decide you that you want one, you may request a jury trial by filing a formal motion and explaining why you did not ask for one earlier. The judge does not have to grant this motion.

3. **Contents**: The form should be completed in full. It can be typed or handwritten, and it must be legible. If you need more space to answer a question, use separate sheets of 8½ x 11-inch paper and attach them to your complaint. You must provide the facts of your case but need not include legal arguments or references to cases. The complaint must contain an original signature (in ink or pencil) from each plaintiff. Photocopies of your signature cannot be accepted. The complaint does not have to be notarized.

4. **Copies**: You must send the Pro Se Office the original complaint plus two identical copies. You should keep another copy for your records. Copies may be handwritten or typewritten but all copies (including any attached exhibits) must be identical to the original.

5. **Fee**: The filing fee is $350.00, plus a $50 administrative fee (the $50 administrative fee does not apply to persons granted *in forma pauperis* status) – the total is payable to the "Clerk of Court, USDC, SDNY," by certified check, bank check, money order, major credit card, or cash (if your complaint is submitted in person). Personal checks are *not* accepted.

6. **Inability to pay the filing fee**: If you are unable to afford the filing fee, you may ask the Court to waive the fee by completing the enclosed Request to Proceed *in Forma Pauperis* ("IFP Application") and including it with your original complaint. The caption of this application must be identical to the caption on the complaint. If there is more than one plaintiff in your case, each plaintiff must provide a separate IFP Application. If you are confined in a jail, prison, or any other correctional facility, you must also complete a Prisoner Authorization Form and attach it to the IFP Application. Even if the Court grants a prisoner's application to proceed *in forma pauperis*, under the Prison Litigation Reform Act of 1995, 28 U.S.C. § 1915(b), the Court must collect the filing fee in installments by debiting your inmate account.

7. **Filing**: When you have completed the forms, mail the original and two copies of the complaint, along with the full filing fee or the Request to Proceed *In Forma Pauperis* and Prisoner Authorization Form, if applicable, to the Pro Se Office at the address above.

8. **Serving the complaint**: Do not serve the complaint on any defendants until the Court sends you instructions about service.

9. **Language**: All papers must be submitted in English. All Court proceedings will be held in English. If you have difficulty understanding or writing in English, you should ask a relative or friend to help you prepare your papers, and you should bring someone to act as your interpreter whenever you come to Court.

10. **Questions**: If you have any questions, please contact the Pro Se Office, (212) 805-0175, during business hours, 8:30 a.m.–5:00 p.m., Monday–Friday (except federal holidays). Please note that the Pro Se Office cannot accept collect calls.

*** These instructions should not be submitted with your complaint ***

Rev. 05/2013


NEW YORK STATE
IDENTIFICATION CARD
USA
ID 609 303 026
Class ID
JOSEPH
BEVERLY DIANE
473 W 158TH ST 71
NEW YORK, NY 10032
Sex F Height 5'-10" Eyes BRO
DOB 09/27/1961
Expires 09/27/2016
E NONE
R NONE
Issued 02/28/2014
SEP 61
EXCELSIOR

OMB No. 1615-0091; Expires 05/31/2011

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form N-565, Application for Replacement Naturalization/Citizenship Document

START HERE - Please type or print in black ink

For USCIS Use Only

Returned	Receipt
Resubmitted	
Reloc Sent	
Reloc Rec'd	
☐ Applicant Interviewed	

☐ Declaration of Intention verified by

☐ Citizenship verified by

Remarks

Action Block

To Be Completed by *Attorney or Representative*, if any.

☐ Fill in box if Form G-28 is attached to represent the applicant.

VOLAG#

ATTY State License #

Part 1. Information about you.

Family Name	Given Name	Middle Name
Joseph	Beverly	Marie

Address - In care of:

Street Number and Name	Apt. Number
473 West 158 Street	7I

City or Town	State or Province
New York	New York

Country	Zip or Postal Code
United States of America	10032

Date of Birth (mm/dd/yyyy)	Country of Birth
September 27, 1961	Antigua

Certificate Number	A-Number

Telephone Number (with area/country codes)	E-Mail Address (if any)
917 605 0543	allisten2000@yahoo.com

Part 2. Type of application

1. I hereby apply for: (check one)

a. ☐ New Certificate of Citizenship
b. ☒ New Certificate of Naturalization
c. ☐ New Certificate of Repatriation
d. ☐ New Declaration of Intention
e. ☐ Special Certificate of Naturalization to obtain recognition of my U.S. citizenship by a foreign country. (Skip Number 2 and go to Part 3)

2. Basis for application: (Refer to the instructions for additional information.)

a. ☒ My certificate is/was lost, stolen or destroyed (attach a copy of the certificate if you have one.) Explain when, where and how.
My Private and Personal Residence was burglarized and all of my Property Stolen June 24, 2013

b. ☐ My certificate is mutilated (attach the certificate).
c. ☐ My name has been changed (attach the certificate).
d. ☐ My certificate or declaration is incorrect (attach the document(s)).

Part 3. Processing information

Gender	Height	Marital Status		
☐ Male ☒ Female	5'10	☒ Single	☐ Married	☐ Widowed ☐ Divorced

My last certificate or Declaration of Intention was issued to me by:

USCIS Office or Name of Court:	Date (mm/dd/yyyy):
New York State Supreme Court	03/30/1988

Name in which the document was issued:
Beverly Marie Joseph

Other names I have used (if none, so indicate):
Beverly P. Joseph

Since becoming a citizen, have you lost your citizenship in any manner?

☒ No ☐ Yes (attach an explanation)

Part 4. Complete if applying for a new document because of a name change

Name changed to present name by: (check one)

☐ Marriage or divorce on (month/day/year) (Attach a copy of marriage or divorce certificate)

☐ Court Decree (month/day/year) (Attach a copy of the court decree)

Part 5. Complete if applying to correct your document

If you are applying for a new certificate or Declaration of Intention because your current one is incorrect, explain why it is incorrect and attach copies of the documents supporting your request.

N/A

Part 6. Complete if applying for a special certificate of recognition as a citizen of the U.S. by the government of a foreign country

Name of Foreign Country

Information about official of the country who has requested this certificate (if known)

Name | Official Title

N/A

Government Agency:

Address: Street Number and Name | Suite Number

City | State/Province

Country | Zip or Postal Code

Part 7. Signature

Read the information on penalties in the instructions before completing this part. If you are going to file this application at a USCIS office in the United States sign below. If you are going to file this application at a USCIS office abroad, sign it in front of a USCIS or Consular Official.

I certify, or if outside the United States, I swear or affirm, under penalty of perjury under the laws of the United States of America, that this application and the evidence submitted with it is all true and correct. I authorize the release of any information from my records which U.S. Citizenship and Immigration Services needs to determine eligibility for the benefit I am seeking.

Signature | **Date** *(mm/dd/yyyy)* 10/03/2014

Signature of USCIS or Consular Official | Print Your Name | Date *(mm/dd/yyyy)*

NOTE: *If you do not completely fill out this form or fail to submit required documents listed in the instructions, you may not be found eligible for a certificate and this application may be denied.*

Part 8. Signature of person preparing form, if other than the applicant

I declare that I prepared this application at the request of the applicant and it is based on all information of which I have knowledge.

Signature | **Print Your Name** | **Date** *(mm/dd/yyyy)*

Firm Name and Address | Telephone Number (with area code)

E-Mail Address (if any)

GPO U.S. GOVERNMENT PRINTING OFFICE: 2010—366-321

Request for Fee Waiver

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-912
OMB No. 1615-0116
Expires 05/31/2015

▶ **Before you fill out this form, please read the instructions.**

FOR USCIS USE ONLY

Application Receipted At *(check only one box):*

USCIS Field Office

☐ Fee Waiver Approved
Date: _____

☐ Fee Waiver Denied
Date: _____

USCIS Service Center

☐ Fee Waiver Approved
Date: _____

☐ Fee Waiver Denied
Date: _____

Section 1. Information About You *(Provide information about yourself. If you are applying for a minor child, **provide information about the minor child.**)*

Line 1. a. Family Name (Last Name): Joseph

Line 1. b. Given Name (First Name): Beverly

Line 1. c. Middle Initial: Vianel

Line 2. Alien Registration Number ▶ A-

Line 3. Date of Birth *(mm/dd/yyyy)* ▶ 09/27/1961

Line 4. Marital Status
☒ Never Married ☐ Divorced ☐ Marriage Annulled
☐ Married ☐ Widow(er) ☐ Legally Separated

Line 5. Applications and Petitions (Enter the form number(s) of the application(s) and/or petition(s) for which you are requesting a fee waiver.)

Biometrics services fees, where applicable, will be included in the fee waiver request.

N-565

Section 2. Additional Information for Dependent(s)

Line 6. Complete the Table below if applicable. *(If you need more space, attach a separate sheet of paper.)*

Name (First, MI, Last)	A-Number (If applicable)	Is Individual Included in Fee Waiver Request?	Date of Birth *(mm/dd/yyyy)*	Relationship to You
Beverly Vianel Joseph	A-	☒ Yes ☐ No	09/27/1961	SELF
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		
	A-	☐ Yes ☐ No		

(B)

Section 3. Basis for Your Request ***(Check any that apply. For additional information, see the form instructions.)***

Line 7. a. ☐ I am or a relevant member of my household is currently receiving a means-tested benefit. *(Complete **Sections 4** and 7.)*

Line 7. b. ☒ My household income is at or below 150% of the Federal Poverty Guidelines. *(Complete **Sections 5** and 7.)*

Line 7. c. ☐ I have a financial hardship. *(Complete **Sections 5, 6** and 7.)*

Section 4. Means-Tested Benefit

Line 8. **Complete the Table Below** *(If you need more space, attach a separate sheet of paper.)*

Name of Person Receiving the Benefit	Name of Agency Awarding Benefit	Date Benefit Was Awarded	Is This Benefit Being Received Now?
Beverly Dianne Joseph	Social Security Admin	10/16/2001	☒ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Section 5. Household Income ***(Provide evidence of monthly income or other support.)***

Line 9. Other than you, how many others in your household depend on the stated income? SE/F ▶ 1

(round to the nearest dollar)

Line 10. Average monthly wage income from household members ▶ $1,080.00

Line 11. Enter other money received each month that is not included in **Line 14.** (This could include spousal support, child support, unemployment, etc.) ▶ $1,080.00

TOTAL (USCIS will compare this amount to Federal Poverty Guidelines) ▶ $1,080.00

Section 6. Financial Hardship

Line 12. Describe your particular situation. Be sure to include how this situation has caused you to incur costs (and what the costs were) or loss of income that you have experienced (and what that loss was). Complete this section in English; otherwise, provide an accompanying English translation. *(If you need more space, attach a separate sheet of paper.)*

My American Passport was Stolen From my Assigned Dormitory Bathroom Hook while Cleaning my self at 9:05 - 9:30 March 4, 2014 Dorm # 601 of Tillary Public Street Shelter 200 Tillary Street, Brooklyn, New York 11201. My American Passport Replacement is Contingent upon my Replacement American Naturalization Certificate of which my Original American Naturalization Certificate was Stolen From my Personal Residence during a Staged Illegal Eviction in the Middle of U.S.A. HUD Section 8 Jurisdiction.

If you are currently unemployed, you must complete Lines 13 and 14.

Line 13. Date that you became unemployed *(mm/dd/yyyy)* ▶ 04/08/2008

Line 14. Amount of unemployment compensation (monthly) that you are receiving (enter dollars) — 0 —

Line 15. List your assets and the value of your assets. *(If you need more space, attach a separate sheet of paper.)*

Type of Asset	Value (enter dollars)
All of my Properties, Assets, Collectibles Properties were Stolen From My Rent Stabilized Section 8 Voucher Permanent Resident Private Home of 7 Years; My Properties Dates From June 1980 through June 24, 2013	
TOTAL Value of Assets	$20,000.00

(R)

Section 6. Financial Hardship *(Cont'd)*

Line 16. List your average monthly costs, and provide evidence of monthly payments where possible. *(If you need more space, attach a separate sheet of paper.)*

Type of Cost	Value (Enter Dollars)	Type of Cost	Value (Enter Dollars)
Rent	$1,237.64	Loan Payment	—
Mortgage	N/A	Commuting Costs	$30/Week
Food	$20 Dollars/Day	Medical	-0-
Utilities	-0-	School	Replacement of Customs Tuitions + Photocopies
Child/Elder Care	-0-	Other Expenses	↓
Insurance	-0- Medicare	**TOTAL Monthly Costs**	$1,307.64

Section 7. Your Signature and Authorization

Do not sign your Form I-912 until it is complete and you are ready to file.

I take full responsibility for the accuracy of all the information provided, including all supporting documentation. I authorize the release of any information, including the release of my Federal tax returns, that USCIS needs to determine my eligibility.

Each person applying for a fee waiver request must sign Form I-912. This includes individuals identified in Sections 1 and 2 if 14 years of age or older. ***(If you need more space, attach a separate sheet of paper.)***

Line 17. Your Signature [Beverly Diane Sargent] Date *(mm/dd/yyyy)* ▶ 10/03/2014

Printed Name Beverly Diane Sargent

Line 17.1. Additional Signature Date *(mm/dd/yyyy)* ▶

Printed Name

Line 17.2. Additional Signature Date *(mm/dd/yyyy)* ▶

Printed Name

Line 17.3. Additional Signature Date *(mm/dd/yyyy)* ▶

Printed Name

Line 17.4. Additional Signature Date *(mm/dd/yyyy)* ▶

Printed Name

E

Section 7. Your Signature and Authorization *(continued)*

Line 17.5. Additional Signature | Date *(mm/dd/yyyy)* ▶

Printed Name

Line 17.6. Additional Signature | Date *(mm/dd/yyyy)* ▶

Printed Name

Line 17.7. Additional Signature | Date *(mm/dd/yyyy)* ▶

Printed Name

MONTEFIORE
Moses Emergency Department
111 East 210th Street
Bronx, NY 10467
718.920.5731

Patient: JOSEPH, Beverly
DOB: 09/27/1961 Sex: Female
Age: 40 - 55 yr
Med Rec# 01375376
Account# 287159297

PATIENT HOME CARE INSTRUCTIONS

Our doctors and staff appreciate your choosing us for your emergency medical care needs. Read these aftercare instructions carefully. Please call us if you have any questions about your medical problem. We are here to serve you.

HEAD INJURY

You have suffered a minor head injury. You do not need to stay in the hospital any longer, but you should have someone with you to check your condition every few hours for the next 24 hours. You may go to sleep, but someone should wake you up several times during the night (every 2-4 hours) to make sure you know who and where you are, and that you are able to talk and move around normally. You should see your doctor or go to the emergency room at once if any of the following symptoms develop over the next few days:

* Severe headaches not helped by pain medicine.
* Vomiting more than 2-3 times.
* Mental confusion, restlessness, or personality changes.
* Increasing weakness, sleepiness, blackouts, or seizures.
* Loss of balance or trouble with movement or coordination.
* A clear or bloody drainage from the nose or ear.

You should get plenty of rest over the next 2-3 days. Avoid using aspirin or alcohol; take acetaminophen (Tylenol) as needed for headache or other pain.

Head injuries may cause a moderate headache, weakness, dizziness, nausea, and depression for up to a week or more after the injury. This post-injury state usually gets better with bed rest and mild pain medicine. If any of these symptoms last for more than a week, you will need further medical attention. Please call the emergency room or your doctor if you have any questions or concerns about your head injury.

PRESCRIPTIONS

Fill all the prescriptions ordered by your doctor and take them as directed. Generic medicines are as good as brand names, and often less expensive.

* If you have been given an antibiotic, be sure to take all of it.
* Keep your drugs out of the reach of children, in a cool, dry, dark place.
* Don't give your medicine to other people or use it for other illnesses.
* Stop your medicine and call us right away if you have drug allergy symptoms or bad side-effects. Call also if you vomit or cannot swallow the medicine.
* Bring your medicines with you any time you go to emergency for treatment.

Ask your doctor or pharmacist about drug or food interactions that may be important to know about when taking your prescription or herbal medicines.

ACETAMINOPHEN

Your doctor recommends acetaminophen (Tylenol, Datril, Tempra, Liquiprin) to treat your present problem. This medicine is given for fever control and to relieve mild pain. Acetaminophen comes in both liquid and tablet form. Be sure to check the label for the dose. Acetaminophen drops have 80 mg/dropper,

the elixir has 160 mg/teaspoon. Every 4 hours you may safely take:

Infants - 40-80 mg
Toddlers - 120-160 mg
School-age children - 240-400 mg
Adults - 500-1,000 mg
The maximum adult dose of acetaminophen is 4 gm per day.

Children up to 12 years old should not take this medicine for more than 5 days in a row; adults should limit use to 10 consecutive days. Please do not drink alcoholic beverages while you are taking this medicine because this can increase the risk of liver damage. If you have liver problems, you should not take this medicine before consulting with your doctor or pharmacist. Contact your doctor if your medicine does not help treat your symptoms, or if you are worried about side effects.

ADDITIONAL INSTRUCTIONS

Call 855-711-7571 for results of HIV tests performed in the Emergency Department. To protect yourself from HIV, always use condoms and never share syringes. For more information, visit the website below: Llame al 855-711-7571 para los resultados de sus pruebas de VIH realizadas en el Departamento de Emergencias. Para protegerse contra el VIH, siempre use condones y nunca comparta jeringas. Para más información, visite el sitio Web:http://www.health.ny.gov/diseases/aids/facts/questions/index.htm

FOLLOW-UP CARE

Your physician today has been DR. Ryan ZAPATA, MD
For follow-up care you have been referred to the following doctor or clinic:
YOUR DOCTOR
Please make an appointment for further treatment as needed or in ___ days. Tell your referral doctor or clinic that we have sent you, and bring your medicines and instructions to the office. If you had x-rays, an EKG, or lab tests today, they have been reviewed by your doctor. We will contact you at once if other important findings are noted after further review by our staff. If you do not continue to improve or if your condition worsens, please call your doctor or the emergency department right away so you can be examined.

I acknowledge receipt of these instructions. I understand that my condition may require more care and will arrange for further treatment as recommended.

Staff Signature

Patient or Representative Signature

Monday, November 10, 2014 - 15:43

The Brooklyn Hospital Center
How Brooklyn stays healthy.
121 DeKalb Avenue
Brooklyn, NY 11201
718.250.8000

EMERGENCY DEPARTMENT INSTRUCTION SUMMARY

EXITCARE® PATIENT INFORMATION

Patient Name: BEVERLY JOSEPH
Attending Caregiver: Leber, Mark J.

Facial and Scalp Contusions

You have a *contusion* (bruise) on your face or scalp. Injuries around the face and head generally cause a lot of swelling, especially around the eyes. This is because the blood supply to this area is good and tissues are loose. Swelling from a contusion is usually better in 2-3 days. It may take a week or longer for a "black eye" to clear up completely.

HOME CARE INSTRUCTIONS

- Apply ice packs to the injured area for about _____ minutes, _____ times a day, for the first couple days. This helps keep swelling down.
- Use mild pain medicine as needed or instructed by your caregiver.
- You may have a **mild** headache, slight dizziness, nausea, and weakness for a few days. This usually clears up with bed rest and mild pain medications.
- Contact your caregiver if you are concerned about facial defects or have any difficulty with your bite or develop pain with chewing.

SEEK IMMEDIATE MEDICAL CARE IF:

- You develop severe pain or a headache, unrelieved by medication.
- You develop unusual sleepiness, confusion, personality changes, or vomiting.
- You have a persistent nosebleed, double or blurred vision, or drainage from the nose or ear.
- You have difficulty walking or using your arms or legs.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 01/25/2006 Document Revised: 12/06/2012 Document Reviewed: 11/02/2012

FOLLOW-UP INSTRUCTIONS

03 days: Medicine Clinic - - (718)250-8425 - -

The exam and treatment that you received today has been provided on an emergency basis only. If your problem worsens or new symptoms appear, contact your doctor or return to this facility for further care.

The Brooklyn Hospital Center
How Brooklyn stays healthy.
121 DeKalb Avenue
Brooklyn, NY 11201
718.250.8000

EMERGENCY DEPARTMENT INSTRUCTION SUMMARY

EXITCARE® PATIENT INFORMATION
DISCHARGE INSTRUCTION SUMMARY

Patient/Visit Information:

Patient Name: BEVERLY JOSEPH	Discharge Date/Time: 11/6/2014 10:25:53 PM
Attending Caregiver: Leber, Mark J.	Diag:

Discharge Instruction Sheets Provided:
Facial and Scalp Contusions

Patient Instructions:

Followup Appointments/Instructions:
Primary Follow-up Information
: - (000)000-0000

Follow-up information for Facial and Scalp Contusions

03 days: Medicine Clinic - - (718)250-8425 - -

Roosevelt Hospital Emergency Department

1000 Tenth Avenue New York, NY 10019
212-523-6800

Take-Home Instructions for the Patient

Patient's Name: Joseph, Beverly D **Date: 11/07/14 15:26:30**
Medical Record Number: 100004222252 **Date of Service: 11/07/2014 14:32**
Diagnosis: Minor head injury (959.01)
Emergency Attending Physician: MD JOSHUA QUAAS
Emergency Resident Physician:
Emergency Physician's Assistant:
Emergency Primary Nurse: NAVIETA BHUDU, RN
Primary Care Provider: * YOUR PRIVATE PHYSICIAN/CLINIC

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. For patients receiving imaging studies, (e.g. x-rays), please be advised that all study interpretations are preliminary and are followed by a review and final report. If there is a significant change in interpretation you will be notified.

If you have questions relating to the treatment you received today in the emergency department, please call: 212-523-6800

Referral/Appointment:
Refer Patient To:: * YOUR PRIVATE PHYSICIAN/CLINIC
PMD/Clinic not in list: at Bellevue
Follow-up in: as needed

Call to arrange an appointment ***immediately***, to ensure you get an appointment for follow-up care within the indicated time frame. If for any reason the doctor you have been referred to cannot see you for a follow-up appointment, you can obtain additional referrals at 1-877-996-9338.

When you call for an appointment, say that you were referred from this Emergency Department.

If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE DOCTOR LISTED ABOVE

****

If you smoke, you are encouraged to quit in order to live longer, feel better, and heal faster. Quitting will lower your chance of heart attack, stroke, or cancer. The people you live with, especially children, will be healthier. Please contact the following numbers for additional information:

At St. Luke's: (212) 523-4410 At Roosevelt: (212) 523-6056

****

Roosevelt Hospital Emergency Department

1000 Tenth Avenue New York, NY 10019

212-523-6800

FINANCIAL ASSISTANCE

If you are uninsured and unable to pay your hospital bill, you may qualify for Financial Assistance. Please call 212-523-3900 and speak with a Financial Counselor for more information. Information about the Financial Assistance Program is also available on our website:
www.wehealny.com <http://www.wehealny.com>

Roosevelt Hospital Emergency Department

1000 Tenth Avenue New York, NY 10019
212-523-6800

MINOR HEAD INJURY:
You have been diagnosed with a minor head injury.

A minor head injury means that although you DID have trauma to your head, you did not seem to have had a serious injury to your brain. You DID NOT suffer a concussion. A concussion is a slightly more severe form of head injury in which the victim may have lost consciousness for a period of time and demonstrates some evidence of brain injury.

In the absence of serious trauma and either no loss of consciousness or a very brief loss of consciousness, X-Rays and CT scans are usually unnecessary.

Treatment includes mild pain medications and observation at home. Narcotic or strong pain medications are usually not necessary. In most cases, acetaminophen (Tylenol) or ibuprofen (Advil or Motrin) should manage your pain adequately.

After a minor head injury, mild headache may last for days.

Over the next 24 hours:

- Stay with family or friends that can observe your behavior.
- Avoid alcohol or drugs.

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Worsening severe headache.
- Numbness, tingling, or weakness in your arms or legs.
- Fever, neck pain, change of behavior.
- Vomiting, difficulty walking or changes in vision.
- Difficulty waking from sleep with increased confusion.

Roosevelt Hospital Emergency Department

1000 Tenth Avenue New York, NY 10019
212-523-6800

Laboratory Tests and Imaging Studies

Below you will find the results of the lab test and imaging studies done for you while in the Emergency Department. Please bring them to your primary care provider and keep a copy for future reference. This information will help your primary care provider to determine if further diagnostic testing is required.

Laboratory Tests:

Pending Laboratory Tests:

Imaging Studies:

Pending Imaging Studies:

Point-of-Care Tests:

EmSTAT Report of Home Medications, Medications Given and Medications Prescribed

Mount Sinai Roosevelt
1000 Tenth Avenue
New York, NY 10019

Emergency Department 212-523-6800

Name: **Joseph, Beverly** Sex: **F**
MR #: **100004222252** Account #: **000491289922**
DOB: **27-Sep-1961** Age: **53** Weight:
Chief Complaint: **Physical Assault/head Injury**
Prim Diagnosis: **Minor head injury (959.01)**
ED Physician: **QUAAS, JOSHUA - Emergency Medicine**
PCP: *** YOUR PRIVATE PHYSICIAN/CLINIC**

Our records indicate that at the time of discharge you are taking these medications. Please share this list with the physician providing your follow-up care

Allergies:

Penicillins

Home Medications

Recorded by JOSHUA QUAAS, MD - 11/07/2014 15:26

Medication/Route/Dose/Frequency	Last Dose	Disposition	PCP Contacted
Fluphenazine HCl oral		**Continue**	**No**

Comment:

Medications Given in ED

No Medications Given

Medications Prescribed by ED Physician

No Medications Prescribed

Verified By: PCP / EDMD (circle one) Date/Time:

Internal Revenue Service
United States Department of the Treasury

PHILADELPHIA, PA 19255-1498

Tracking ID: 100239943183
Date of Issue: 03-19-2015

BEVERLY JOSEPH
473 W 158TH STREET APT 71
NEW YORK, NY 10032

Taxpayer's Name: BEVERLY D JOSEPH
Taxpayer Identification Number: 580-16-7999
Tax Period or Periods: December, 2014
Return: 1040

Information About the Request We Received

Why We're Contacting You

We're contacting you to report on the status of the request we received.

Information About the Status of The Request

On March 19, 2015, your office submitted a request for taxpayer information.

We received a request dated March 19, 2015 for verification of non-filing of returns for above tax period or periods. We have no record of a filed Form 1040, 1040A, or 1040EZ using the above Social Security Number. You can consider this letter a verification of non-filing.

How To Contact Us

Please call us at 1-800-829-0922 if you have any questions regarding this letter or if you need additional information.

Sincerely Yours,

Patricia LaPosta

Patricia LaPosta, Director
Electronic Products & Svcs Support

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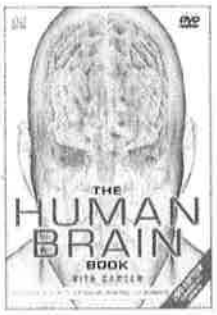
BOOKSELLERS

Store Number 1979 | 2289 Broadway | New York, NY 10024 | (212)362-8835

For assistance in locating any of these products or to place an order, please ask a bookseller.

The Human Brain Book
Rita Carter



Price: $40.00
Medicine, ANAT/PHYSIOLOGY, Anatomy/Physiology, Anatomy/Physiol

Hardcover , 264 pages
DK Publishing, Inc.
03/03/2014
Product # 9781465416025

B & N Sales Rank: 132230

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(See a bookseller to order this item)

HELD ON 1ST FLOOR, ~~ASH~~ AT THE REGISTER

Store Delivery:
2-3 business days
Home Delivery:
Express (Members): Orders arrive in 3-4 business days
Standard (non-Members): Orders arrive in 3-7 business days

About This Item

From Barnes & Noble
Neurophysiologist Sir Charles Sherrington called the human brain "an enchanted loom where millions of flashing shuttles weave a dissolving pattern, always a meaningful pattern though never an abiding one." In the past century, this object of endless fascination has become the subject of increasingly precise and revealing scientific research. This DK guide delicately unlayers the findings of neuroscience research by providing a graphic multimedia guided tour of our brains, how they function when they work and what goes wrong when they don't. Clearly written and abundantly illustrated, *The Human Brain Book* has the potential to instruct and entertain the entire family.

From the Publisher

Combining the latest findings from neuroscience with new brain imaging techniques, as well as developments on infant brains, telepathy, and brain modification, this new edition of DK's *The Human Brain Book* covers brain anatomy, function, and disorders in unprecedented detail.
With its unique 22-page atlas, illustrated with MRI scans, and an interactive DVD, *The Human Brain Book* is a perfect resource for families, students, or anyone interested in human biology, anatomy, and neuroscience.

From The Critics

"[O]ffers extensive, detailed information on the systems of the body and the workings of the human brain." –
RaisingArizonaKids.com

Author Description

Rita Carter is a science and medical writer, and contributes to the Independent, New Scientist, the Daily Mail, and the Telegraph. She has twice been awarded the Medical Journalists' Association prize for outstanding contribution to medical journalism. She has written several books, including Mapping the Mind, Exploring Consciousness (both Weidenfeld and Nicolson), and Multiplicity: the New Science of Personality (Little, brown), which have sold internationally - including the US, Japan, Korea, Poland, Italy, Spain, and Brazil. Mapping the Mind was shortlisted for the Rhone-Poulenc Prize (now the Royal Society Prize for Science books). Rita also talks about the brain, consciousness, and behavior to a wide range of groups at seminars, conferences, and workshops around the world.

Customers Also Recommend

Brain: The Complete Mind
By Michael S. Sweeney

The Complete Human Body: The Definitive Visual Guide
By Alice Roberts Dr.

The Human Body Book (Second Edition)

BELLEVUE HOSPITAL CENTER

462 FIRST AVENUE NEW YORK NY 10016
(212)562-3011

PATIENT EDUCATION MATERIAL

RX# 2299860 Date: 09/09/14
JOSEPH, BEVERLY
Qty: 120 FLUPHENAZINE 5 MG TABLET
Directions: TAKE TWO TABLETS BY MOUTH TWICE DAILY

FLUPHENAZINE ORAL

USES: This medication is used to treat symptoms of a certain type of mental/mood condition (schizophrenia). Fluphenazine belongs to a class of medications called phenothiazines and is also referred to as a neuroleptic. It works by affecting the balance of natural chemicals (neurotransmitters) in the brain. Some of the benefits of continued use of this medication include reduced episodes of hallucinations, delusions, or bizarre behaviors that occur in patients with schizophrenia. This medication is not recommended for use in children under 12 years of age. Also, it should not be used to manage behavioral problems in patients with mental retardation.

HOW TO USE: Take with food or milk if stomach upset occurs unless directed otherwise by your doctor. This medication must be taken as prescribed. Do not stop taking this drug suddenly without consulting your doctor. Some conditions may worsen if the medication is suddenly stopped. Use this medication regularly in order to get the most benefit from it. Remember to use it at the same time(s) each day. Dosage is based on your age, medical condition, and response to therapy. It may take up to two weeks for the full benefit of this medication to take effect. Inform your doctor if your condition does not improve or worsens.

SIDE EFFECTS: Drowsiness, lethargy, dizziness, nausea, loss of appetite, sweating, dry mouth, blurred vision, headache, and constipation may occur. If any of these effects persist or worsen, notify your doctor or pharmacist promptly. To minimize dizziness and lightheadedness, get up slowly when rising from a seated or lying position. Remember that your doctor has prescribed this medication because he or she has judged that the benefit to you is greater than the risk of side effects. Many people using this medication do not have serious side effects. Tell your doctor right away if you have any serious side effects, including: feelings of restlessness, mask-like facial expression, greatly increased saliva, tremors, unusual mental/mood changes (such as depression, worsening of psychosis), confusion, unusual dreams, frequent urination or difficulty urinating, vision problems, weight change, swelling of the feet/ankles, fainting, skin discoloration, butterfly-shaped facial rash, joint pain, seizures. In rare instances, this medication may increase your level of a certain hormone (prolactin). For females, this rare increase in prolactin may result in unwanted breast milk, missing/stopped menstrual periods, or difficulty becoming pregnant. For males, it may result in decreased sexual ability, inability to produce sperm, or enlarged breasts. If you develop any of these symptoms, tell your doctor immediately. Rarely, males may have a painful or prolonged erection lasting 4 or more hours. If this occurs, stop using this drug and get medical help right away, or permanent problems could occur. Fluphenazine may rarely cause a condition known as tardive dyskinesia. In some cases, this condition may be permanent. Tell your doctor immediately if you develop any unusual/uncontrolled movements (especially of the face, mouth, tongue, arms, or legs). This medication

Bellevue Hospital Center , Department of Psychiatry
Unit: 18N , Telephone: 212-562-3467
Admission Date: 8/15/14 , Discharge Date: 9/10/14
Name: Joseph,Beverly , Medical Record Number: 1699654

Adult Discharge and After-care Plan

Dear Ms. Beverly Joseph , family member, or other involved person:

You have just completed your psychiatric hospitalization at Bellevue Hospital Center for an illness which can change thinking, feeling, and behavior. We are glad that you have improved, and if you follow the recommendations below, you will increase your likelihood of continuing to improve.

You have indicated that you agree with the following arrangements. Family or significant others (DHS staff) were involved in the arrangements.

Housing

Your type of housing is: Shelter

The specifics are: Tilliary street women : 200 Tilliary street. Brooklyn NY 11201 718-855-7485

If children, elderly, or other dependents are at home, the following services may be available, and could be contacted for assistance: na

Aftercare

Your type of aftercare is: Follow-up Onsite at your shelter

The specifics are: On site care , your appointment is on 9/12/14

You have the following home-care services: na

Case Management

You are eligible for, but did not agree to intensive case management services.

Financial

You already have, or arrangements have been made for the following entitlements: SSD

The status of the above entitlements, what you must do to follow-up, and other financial issues: na

Medications

Your allergies to medications and other substances are: Penicillins - shock, No known Other allergies

You should avoid the medications or other substances that you are allergic to.

Most medications have side effects. While you were in the hospital, your doctor has worked with you to minimize the side effects of your medications. It is unlikely that new side effects will occur if you take your medications as prescribed. However, let your doctor know immediately if new or troubling side effects appear. If any side effect occurs that you feel is urgent, contact your provider during business hours, or the emergency room during other hours, before taking your next dose.

If you take medications, please see the general information in the section "Useful Information."

Home Medication List

Discharge Medications

FluPHENAZine HCl	10 mg tab by mouth twice each day for -- helps organize thoughts and behavior for schiozphrenia 10 mg 6 m x 12

Other Instructions

Your social worker has the following additional instructions for you:
Mrs. Joseph please take your medication as prescribed, and work with the onsite treatment team at your shelter. They can help you reach your goals.

Please follow the above instructinos carefully. Your doctor or primary therapist does not have additional instructions for you.

Useful Information

Activities

- Try to keep busy. Plan your day in advance. Do not stay by yourself.
- Try to take walks. Exercise within your ability.
- Try to eat with others. Try not to eat more than one meal a day alone.
- Share your feelings when upset.
- Keep your clinic appointments faithfully.
- Take your medications as prescribed.
- Discuss returning to work or school with your doctor if you were advised not to return

immediately.

Medication Instructions

- Sunlight - Some medications can cause excessive sunburn. If your medication does this, please avoid direct exposure to bright sunlight whenever possible. At the beach or when you plan to be outdoors in the bright sun, use sun block and cover your head with a wide brimmed hat.
- Dry Mouth - Drink several glasses of liquid each day. You may wish to use sugarless candy and/or gum to relieve dryness.
- Pregnancy - It is important to talk with your doctor in order to review and possibly adjust your medications if you become pregnant.
- Alcoholic Beverages - Drinking alcoholic beverages (beer, wine, hard liquor, etc.) is not recommended with most psychiatric medications, as you may become excessively drowsy, sluggish, or delelop other serious problems. Many over the counter medications, including cough syrup, contain alcohol.
- Driving and Using Heavy Machinery - Because some medications can lead to drowsiness, do not drive, use heavy machinery, or power tools until you have discussed your response to the medication with your doctor.
- Lithium - If you are taking lithium, regular blood tests are necessary to be sure that you do not have too little or too much lithium in your blood. Consult your physician about salt replacement if you sweat excessively.
- Use of Tobacco - Nicotine, present in all tobacco products (cigarettes, cigars, pipes, chewing tobacco), is highly addictive and interferes with some psychiatric medications. Try to avoid these products.

Other Instructions

- Do not raise, lower, or stop your medications without consulting your doctor, as this could worsen your condition, and make your symptoms return.
- At your first meeting with a doctor, tell him or her the complete list of medications that you take.
- Carry your medication container, even if it is empty, with you whenever you go to a doctor's appointment.
- We recommend that you have an annual physical examination, including a complete blood count and blood chemistries.
- Do not take any new medications, including over the counter, or herbal or nutritional supplements without first talking to your doctor.
- Whenever you visit a doctor, clinic, or emergency department, bring this form with you.

Persons Involved in Discharge and After-care Plan

This discharge and after-care plan has been reviewed with me. My questions have been answered and I understand the instructions.

I agree to allow Bellevue staff to contact my aftercare placement, treatment site(s), and residence for 30 days following discharge.

Beverly A. Joseph September 12, 2014 1:25 PM EST

Beverly Joseph Date

Family or Involved Other Date

The following staff were involved in your care and/or discharge:

Staff	Name
Nurse:	Perez,Guenever, RN
Social Work Staff:	Bobb,Gwendolyn (212-562-3467)
Primary Clinician:	Zuniga,Federico, MD
Attending:	Zuniga,Federico, MD

9/12/14

This form was printed on 9/12/14 11:05

New York City Police Department
Omniform System - Complaints

Report Cmd:	Jurisdiction:	Record Status:	Complaint #:
088	N.Y. POLICE DEPT	Final, No Arrests	2014-088-00612

Occurrence INSIDE OF 200 TILLARY
Location: STREET
Name Of Premise: TILLARY STREET WOMEN'S SHELTER
Premises Type: OTHER
Location Within Premise:
Visible By Patrol?: NO

Precinct: 088
Sector: J
Beat:
Post:

Occurrence From: 2014-02-18 08:00 TUESDAY
Occurrence thru: 2014-02-18 09:30
Reported: 2014-02-18 18:47
Complaint Received: RADIO

Aided #
Accident #
O.C.C.B. #

Classification: GRAND LARCENY
Attempted/Completed: COMPLETED
Most Serious Offense Is: FELONY
PD Code: 438 LARC,GR FROM BUILD UNATTENDED
PL Section: 15530
Keycode: 109 GRAND LARCENY

Case Status: OPEN
Unit Referred To: P.D.U.
Clearance Code:
Log/Case #: 0
File #:
Prints Requested? NO

Is This Related To Stop And Frisk Report	SQF Number:	Was The Victim's Personal Information Taken Or Possessed?	Was The Victim's Personal Information Used To Commit A Crime?
NO	0000-000-00000	NO	NO

Gang Related?	OCCB FOD Log #:	Name Of Gang:	Child Abuse Suspected?
NO			NO

DIR Required?	Child In Common?	Intimate Relationship?
NO	NO	NO

If Burglary:
Forced Entry?
Structure:
Entry Method:
Entry Location:

Alarm:
Bypassed?
Comp Responded?:
Company Name/Phone:
Crime Prevention Survey Requested?:
Complaint/Reporter Present?:

If Arson:
Structure:
Occupied?:
Damage by:

Taxi Robbery:
Partition Present:
Amber Stress Light Activated:
Method of Conveyance:
Location of Pickup:

Supervisor On Scene - Rank / Name / Command :	Canvas Conducted:	Translator(if used):
SGT LONG 088	NO	

NARRATIVE:
AT T/P/O C/V STATES WHILE TAKING A SHOWER UNKNOWN PERP DID REMOVE HER WALLET AND ALL LISTED ITEMS FROM HER LOCKER @ LOCATION. NO WITNESSES OR CAMERA IN ROOMS. P/S NOTIFIED & ECT NOTIFIED.

No NYC TRANSIT Data for Complaint # 2014-088-00612

Total Victims:	Total Witnesses:	Total Reporters:	Total Wanted:
1	0	1	0

VICTIM: # 1 of 1	Name:	Complaint#:
	JOSEPH,BEVERLY	2014-088-00612

Nick/AKA/Maiden:
UMOS: NO
Sex/Type: FEMALE
Race: BLACK
Age: 52
Date Of Birth: 09/27/1961
Disabled? NO
Is this person not Proficient in English?:
If Yes, Indicate Language:
N.Y.C.H.A Resident? NO
Is Victim fearful for their safety / life? NO
Escalating violence / abuse by suspect? NO
Were prior DIR's prepared for C/V? NO

Gang/Crew Affiliation:
Name:
Identifiers:

Will View Photo:
Will Prosecute:
Notified Of Crime Victim Comp. Law: NO

LOCATION	ADDRESS	CITY	STATE/COUNTRY	ZIP	APT/ROOM
HOME-PERMANENT	200 TILLARY STREET	BROOKLYN	NEW YORK	11205	601

Phone #: CELL: 649-417-7011

Action against Victim:

Actions Of Victim Prior To Incident: TAKING A SHOWER

Victim Of Similar Incident:

If Yes, When And Where

REPORTER: # 1 of 1

Name: JOSEPH,BEVERLY

Complaint #: 2014-088-00612

Nick/AKA/Maiden:
Sex/Type: FEMALE
Race: BLACK
Age: 052
Date Of Birth: 09/27/1961
Is this person not Proficient in English?: NO
If Yes, Indicate Language:

Gang/Crew Affiliation: NO
Name:
Identifiers:

Relationship To Victim:

Location	Address	City	State/Country	Zip	Apt/Room
HOME-PERMANENT	200 TILLARY STREET	BROOKLYN	NEW YORK	11205	601

Phone #: CELL: 649-417-7011

PROPERTY:

Complaint #2014-088-00612

Lost/Stolen/Found: STOLEN

Business/Personal/Both?: PERSONAL

Owner Identification Num: NONE

Item	Amt	Article	Description	Serial #	$ Stolen	$ Recovered
1.	1.		TOMMY MARK WALLET BLACK		0.	0.
2.	1.		DEBIT CARDS CITIBANK		0.	0.
3.	1.		NYS ID		0.	0.
4.	1.		SOCIAL SECURITY CARD		0.	0.
5.	1.		INSURANCE CARD		0.	0.
6.	1.		PARKS & REC CARD		0.	0.
7.	1.		LIBRARY CARD		0.	0.
8.	1.		ID CARD USS INTREPID		0.	0.
9.	1.		CLINIC CARD ST LUKES		0.	0.
10.	1.		MED ALERT CARD		0.	0.

TOTALS: STOLEN 0. RECOVERED 0.

EVIDENCE:

Complaint # 2014-088-00612

Evidence Collected?:	Evidence Collection Team/Crime Scene Requested?:	ECT Responded?:	ECT Run#:	Crime Scene Responded?:	Crime Scene Number:

Evidence	Invoice #

No IMEI Data for Complaint # 2014-088-00612

NOTIFICATIONS / ADDITIONAL COPIES:	**Complaint # 2014-088-00612**

Notifications to:

Rank/Title	Name	Unit/Agency	Log #
DET	PUGLIESE	88-PDU	
PO	BATIE	ECT	

Reporting/Investigating M.O.S. Name: POM BEHARRY MARK	**Tax #:** [redacted]	**Command:** 088 PCT	**Rep.Agency:** NYPD
Supervisor Approving Name: SGT DURETS BORIS	**Tax #:** [redacted]	**Command:** 088 PCT	**Rep.Agency:** NYPD
Complaint Report Entered By: SPA AUSTIN	**Tax #:** [redacted]	**Command:** 088 PCT	**Rep.Agency:** NYPD
Signoff Supervisor Name: SGT MOSES	**Tax #:** [redacted]	**Command:** 088 PCT	**Rep.Agency:** NYPD

END OF COMPLAINT REPORT
 # 2014-088-00612

Print this Report

(20)

Saturday, August 08, 2015

00:11:00:00:00:39:00:00:00:1470:036

Eastern Standard Time

P.S. #1 Based upon Premeditated Bias, Malice, Prejudice and Personal Beliefs I Beverly Tinner Joseph is Daily and Habitually Spoken / Verbal Assaulting Attacks of My Cognitive Capabilities and Mental Capacities as the Previously Mentioned Miss Bare Faced, Bold Faced, Brazen, Wanton, Callous CAMBA/FIC Commissioned Black Mustard Clay Brown Female Security Guard On Duty, Saturday August 08, 2015 at 11:11 am Eastern Standard Time.

P.S #2. Miss CAMBA/FIC Black Female Mustard Clay Brown Security Guard On August 08, 2015 On Duty At 11:11 am Eastern Std Time. Daily And Habitually Brutalizes my Assigned

(11)

Saturday, August 08, 2015
Time 11:25 Am Eastern Standard

At 11:11 Am I Beverly Diane Joseph
was standing below the Security
Surveillance Camera On the 3rd Floor
of Magnolia House - CAMBA
1424 Herkimer, Brooklyn, New York
11233 Exhibit 'my wife' to the
Congress of the United States of America
When the Black Mustard Clay Brown
Female CAMBA Security Guard On
Duty Came and Harassed me
as she usually Do Every Day
Since I Beverly Diane Joseph
Arrived by DHS School Bus
June 19, 2015, as the Female
CAMBA Security Assailet Gym
Approached My Self She Stated
"I Am Going to Harass Her
Beverly Joseph, to Loose Her
Babies (Fetuses)."

I Am Seeking a Relief 900
Billion Dollars of Deportation.

Adviser, Commander Chief of the
United States of America Department
of Defense, The United States of America
Military, Worldwide, Chief Health
Administrator of the United States
of America Department of Defense
Hospital Corpsmen Programs,

Beverly Diane Joseph

*** REC 2015215 103749 H46F1881 WHUX CIPQYAA PQAA (F-WHU) ***

1099 DTE:08/03/15 SSN:580-16-7999 DOC:109 UNIT:VB PG: 001

+++++FORM SSA-1099 - SOCIAL SECURITY BENEFIT STATEMENT - 2014+++++
+PART OF YOUR SOCIAL SECURITY BENEFITS MAY BE TAXABLE INCOME FOR 2014.
+USE $ 15537.40 FROM BOX 5 BELOW WITH IRS NOTICE 703 TO SEE IF ANY PART OF YOUR BENEFITS MAY BE TAXABLE ON YOUR FEDERAL INCOME TAX RETURN.
+ALSO SEE ATTACHED GENERAL INFORMATION.

BOX 1. NAME-BEVERLY D JOSEPH
BOX 2. BENEFICIARY SOCIAL SECURITY NUMBER-580-16-7999 (SEE BOX 8 BELOW)
BOX 3. BENEFITS FOR 2014- $ 15537.40 (SEE DESCRIPTION OF AMOUNT IN BOX 3 BELOW)
BOX 4. BENEFITS REPAID TO SSA IN 2014-NONE
(SEE DESCRIPTION OF AMOUNT IN BOX 4 BELOW)
BOX 5. NET BENEFITS (BOX 3 MINUS BOX 4) FOR 2014-$ 15537.40
BOX 6. VOLUNTARY FEDERAL INCOME TAX WITHHELD-NONE
BOX 7. ADDRESS-BEVERLY JOSEPH 17 WINDSOR RD
GREAT NECK NY 11021-2741
BOX 8. CLAIM NUMBER-580-16-7999A (USE THIS NUMBER IF YOU NEED TO CONTACT SSA)

+++DESCRIPTION OF AMOUNT IN BOX 3+++
ADD:

PAID BY CHECK OR DIRECT DEPOSIT	$ 14845.00
MEDICARE PART B	$ 692.40
MEDICARE PART C	$ 0.00
MEDICARE PART D	$ 0.00
WORKERS COMPENSATION OFFSET	$ 0.00
DEDUCTIONS FOR WORK OR OTHER ADJUSTMENTS	$ 0.00
PAID TO ANOTHER FAMILY MEMBER	$ 0.00
ATTORNEY FEES	$ 0.00
VOLUNTARY FEDERAL INCOME TAX WITHHELD	$ 0.00
TREASURY BENEFIT PAYMENT OFFSET, GARNISHMENT AND/OR TAX LEVY	$ 0.00
TOTAL ADDITIONS	$ 15537.40

SUBTRACT:

NONTAXABLE PAYMENTS	$ 0.00
AMOUNTS FOR OTHER FAMILY MEMBERS PAID TO YOU	$ 0.00
TOTAL SUBTRACTIONS	$ 0.00
BENEFITS FOR 2014 (AMOUNT SHOWN IN BOX 3)	$ 15537.40

+++DESCRIPTION OF AMOUNT IN BOX 4+++
ADD:

CHECKS RETURNED TO SSA	$ 0.00
DEDUCTIONS FOR WORK OR OTHER ADJUSTMENTS	$ 0.00
OTHER REPAYMENTS	$ 0.00
BENEFITS REPAID TO SSA IN 2014 (AMOUNT SHOWN IN BOX 4)	$ 0.00

SUSPECT SOCIAL SECURITY FRAUD?

Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

IF YOU HAVE QUESTIONS

We invite you to visit our web site at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local office at 866-758-1318. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
5TH FLOOR
211 STATION RD
MINEOLA, NY 11501

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

OFFICE MANAGER

SOCIAL SECURITY ADMINISTRATION

Date: August 3, 2015
Claim Number: XXX-XX-7999A
XXX-XX-7999DI

BEVERLY JOSEPH
17 WINDSOR RD
GREAT NECK NY 11021-2741

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

Information About Current Social Security Benefits

Beginning December 2014, the full monthly Social Security benefit before any deductions is.....$ 1215.90

We deduct $115.40 for medical insurance premiums each month.

The regular monthly Social Security payment is.....$ 1100.00
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the third of each month.

Information About Past Social Security Benefits

From June 2014 to November 2014, the full monthly Social Security benefit before any deductions was.....$ 1195.60

We deducted $115.40 for medical insurance premiums each month.

The regular monthly Social Security payment was.....$ 1080.00
(We must round down to the whole dollar.)

Medicare Information

You are entitled to hospital insurance under Medicare beginning October 2002.

You are entitled to medical insurance under Medicare beginning July 2014.

BEVERLY DIANE JOSEPH
473 WEST 158 Street
APARTMENT # 71
NEW YORK, NEW YORK 10007

ATTN: PRO SE OFFICE
ROOM 200

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
500 PEARL STREET
NEW YORK, NEW YORK 10007